ACCIDENT REPORT FORM PLEASE COMPLETE WITHIN 24 HRS

Date: _____ Day: _____ Time: _____

Name of Facility: _____

Personal Data of Injured Party:

Name:_____ Age:_____ Sex:_____

Address:_____ City:_____ State:_____ Zip:_____

Work Phone:_____ Home Phone:_____

Where did accident occur (be specific)?_____

When did accident occur (indicate date & time)?_____

In what program was injured party participating? General Program ☐ Professional Program ☐
Intramural Activity ☐ Other ☐

In what activity was injured party participating when accident occurred?_____

What equipment, if any, was involved in accident?_____

Was there supervision at the time of the accident? YES ☐ NO ☐
If yes, by whom?_____

What type of injury was incurred? (i.e. bruise, laceration, etc.)_____

Describe in detail how accident occurred?_____
_____
_____
_____
_____
_____

Was 911 Called: YES ☐ NO ☐ If Yes, who called? _____
Was first aid administered? YES ☐ NO ☐
If yes, what kind & by whom?_____

Was injured party referred to medical assistance? YES ☐ NO ☐
Name of person who accompanied injured person to medical assistance:_____

Witnesses information:

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

Staff Signature:_____ Date:_____

Return to deken@rentonwa.gov or fax to 425.430.6701 within 24 hrs of incident.